

AMEND SECTION 30-757 TO READ:

30-757.

- .17 **Protective sSupervision** ~~is twenty-four-hours-a-day of continuous care~~ consisting of observing and monitoring recipient behavior in order to safeguard the recipient against injury, hazard, or accident.
- .171 ~~This service~~ Protective Supervision is available for monitoring and observing the behavior of non self-directing, confused, mentally impaired, or mentally ill persons, ~~with the following exceptions~~
- (a) ~~Protective supervision does not include friendly visiting or other social activities.~~
 - (b) ~~Supervision is not available when the need is caused by a medical condition and the form of the supervision required is medical.~~
 - (c) ~~Supervision is not available in anticipation of a medical emergency.~~
 - (d) ~~Supervision is not available to prevent or control anti-social or aggressive recipient behavior.~~
 - (a) The Protective Supervision twenty-four-hours-a-day continuous care may be provided through the following, or combination of the following arrangements:
 - (1) In-Home Supportive Services program;
 - (2) Alternative resources such as Adult or Child Day Care Centers, community resource centers, Senior Centers; respite centers;
 - (3) Voluntary resources.
- .172 ~~Protective supervision is available under the following conditions:~~
- (a) ~~Social service staff have determined that a twenty-four-hour need exists for protective supervision and that the recipient can remain at home safely if protective supervision is provided.~~
 - (b) ~~Services staff determine that the entire twenty-four-hour need for protective supervision can be met through any of the following, or combination of the following:~~
 - (1) ~~IHSS~~
 - (2) ~~Alternative resources.~~
 - (3) ~~A reassurance phone service when feasible and appropriate.~~

.172 Protective Supervision is not available under the following conditions:

- (a) Friendly visiting or other social activities;
- (b) A medical condition where the type of supervision required is medical;
- (c) In anticipation of a medical emergency;
- (d) To prevent or control anti-social or aggressive recipient behavior.

.173 Protective Supervision is only available under the following conditions as determined by social service staff:

- (a) At the time of the initial assessment , a need exists for twenty-four-hours-a-day of continuous care in order for the recipient to remain at home safely.
 - (1) For a person needing Protective Supervision, the county social services staff shall request that the “Assessment of Need for Protective Supervision” form be completed by a physician or other appropriate medical professional and returned to the county.
 - (2) The “Assessment of Need for Protective Supervision” form shall be used in conjunction with other pertinent information, such as an interview or report by the social service staff or a Public Health Nurse, to assess the person's need for Protective Supervision.
 - (3) The completed “Assessment of Need for Protective Supervision” form shall not be determinative, but considered as one indicator of the need for Protective Supervision.
 - (4) In the event that the “Assessment of Need for Protective Supervision” form is incomplete or fails to be submitted to the county, the county social services staff shall make its determination of need based upon other available evidence as specified below in Handbook.

HANDBOOK BEGINS HERE

- (5) Examples of other available evidence the county social services staff may use are:
 - (A) A Public Health Nurse interview;
 - (B) Police reports;
 - (C) Collaboration with Adult Protective Services, Linkages, and/or other social service agencies;
 - (D) The social service staff's own observations.

HANDBOOK ENDS HERE

(b) At the time of reassessment of a person receiving authorized Protective Supervision, the county social service staff shall determine the need to obtain an updated "Assessment of Need for Protective Supervision" form (SOC 821).

(1) An updated Assessment of Need form shall be requested if determined necessary, and shall be documented in the recipient's case file by the county social service staff.

(c) As with all types of IHSS services, recipients may request protective supervision. Recipients may obtain documentation from their physicians or other sources for submission to the county social service staff.

~~.174~~ (Reserved)

~~.173~~4 Social services staff shall discuss the Protective Service twenty-four-hours-a-day continuous care plan with the recipient, or the recipient's guardian or conservator, and the appropriateness of out-of-home care as an alternative to pProtective sSupervision.

.175 (Reserved)

30-761 NEEDS ASSESSMENT STANDARDS 30-761

AMEND SECTION 30-761 TO READ:

- .1 Services shall be authorized only in cases which meet the following conditions:
 - .11 The recipient is eligible as specified in Sections 30-755 or 30-780, except that services may be authorized on an interim basis as provided in Section 30-759.3.
 - .12 A needs assessment establishes a need for the services identified in Section 30-757 consistent with the purposes of the IHSS program, as specified in Section 30-~~700.150~~, except as provided in Section 30-759.8.
 - .13 Social services staff of the designated county department has had a face-to-face contact with the recipient in the recipient's home at least once within the past 12 months, except as provided in Sections 30-761.213 through .215, and has determined that the recipient would not be able to remain safely in his/her own home without IHSS. If the face-to-face contact is due but the recipient is absent from the state but still eligible to receive IHSS pursuant to the requirements stated in Section 30-770.4, Residency, the face- to-face requirement is suspended until such time as the recipient returns to the state.
 - .14 Performance of the service by the recipient would constitute such a threat to his/her health/safety that he/she would be unable to remain in his/her own home.

30-761 NEEDS ASSESSMENT STANDARDS (Continued) 30-761

.2 Needs Assessments

AMEND SECTION 30-761.21 TO READ:

- .21 Needs assessments are performed:
- .211 Prior to the authorization of IHSS services when an applicant is determined to be eligible, except in emergencies as provided in Section 30-759.8.
 - .212 Prior to the end of the twelfth calendar month from the last face-to-face assessment except as provided in Sections 30-761.213 through .215.
 - (a) If a face-to-face reassessment is completed before the twelfth calendar month, the month for the next reassessment shall be adjusted to the 12-month requirement except as provided in Sections 30-761.213 through .215.
 - .213 Except for IHSS Plus Waiver cases, prior to the end of the eighteenth calendar month from the last reassessment if the county opts to extend assessments up to six months beyond the regular 12-month period on a case-by-case basis and all the following conditions exist, except as provided in Section 30-761.214:
 - (a) The recipient had at least one reassessment since the initial program intake assessment; and
 - (b) The recipient's living arrangement has not changed since the last annual assessment; and:
 - (1) The recipient lives with others; or
 - (2) Has regular meaningful interaction with persons other than his/her provider; and
 - (c) The recipient is able to satisfactorily direct his/her care; or:
 - (1) If the recipient is a minor, his/her parent or legal guardian is able to satisfactorily direct the recipient's care; or
 - (2) If the recipient is incompetent, his/her conservator is able to satisfactorily direct the recipient's care; and
 - (d) There has not been any known change in the recipient's supportive services needs in the previous 24 months; and
 - (e) There have not been any reports to, or involvements of, an adult protective services agency or other agencies responsible for addressing the health and safety of individuals since the last assessment that are documented in the case record; and
 - (f) The recipient has not had a change in provider(s) in the previous six months; and

- (g) The recipient has not reported a change in his/her supportive services needs that requires a reassessment; and
 - (h) The recipient has not been hospitalized in the previous three months.
- .214 If some, but not all, conditions specified in Section 30-761.213 (a) through (h) are met, the county may consider other factors in determining if the extended assessment period is appropriate. The factors include, but are not limited to:
- (a) Involvement in the recipient's care from a social worker or case manager of a human services agency, such as Multi Services Seniors Program (MSSP), Linkages, a regional center, or county mental health program; or
 - (b) Prior to the end of the twelfth calendar month following the last assessment, the county receives a medical report from a physician or other licensed health care professional that states the recipient's medical condition is not likely to change.
- .215 If the county extends the reassessment period as provided in Section 30-761.213 through .214, the county shall document the basis of the decision.
- .213 6 ~~Whenever~~ the county has information indicating that the recipient's physical/mental condition, or living/social situation need for supportive services is expected to decrease in less than 12 months, the county may reassess the recipient's needs in less than 12 months since the last assessment.
- .217 The county shall reassess the recipient's need for services:
- (a) Any time the recipient notifies the county of a need to adjust the service hours authorized due to a change in circumstances; or
 - (b) When there are other indications or expectations of a change in circumstances affecting the recipient's need for supportive services.
- .22 Repealed by Manual Letter No. 82-67 (10/1/82).
- .23 The designated county department shall not delegate the responsibility to do needs assessments to any other agency or organization.
- .24 The needs assessment shall identify the types and hours of services needed and the services which will be paid for by the IHSS program.
- .25 No services shall be determined to be needed which the recipient is able to perform in a safe manner without an unreasonable amount of physical or emotional stress.

ASSESSMENT OF NEED FOR PROTECTIVE SUPERVISION FOR IN-HOME SUPPORTIVE SERVICES PROGRAM

☐ Release of Information Attached

PATIENT'S NAME:		PATIENT'S DOB:
MEDICAL ID#: (IF AVAILABLE)	COUNTY ID#:	
IHSS SOCIAL WORKER'S NAME:		
COUNTY CONTACT TELEPHONE #:	COUNTY FAX #:	

Your patient is an applicant/recipient of **In-Home Supportive Services (IHSS)** and is being assessed for the need for Protective Supervision. Protective Supervision is available to safeguard against accident or hazard by observing and/or monitoring the behavior of non self-directing, confused, mentally impaired or mentally ill persons.

Protective Supervision is not available when: (1) the need for supervision is caused by a physical condition rather than a mental impairment;

- (2) prevention or control of antisocial or aggressive behavior is necessary (including self-destructive behavior, destruction of property, or harming others); or

- (3) a medical emergency (such as seizures, etc.,) is anticipated.

Please complete this form and return it promptly. Thank you for your assisting us in determining eligibility for Protective Supervision.

DATE PATIENT LAST SEEN BY YOU:	LENGTH OF TIME YOU HAVE TREATED PATIENT:
DIAGNOSIS/MENTAL CONDITION:	PROGNOSIS: <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary - Timeframe: _____

PLEASE CHECK THE APPROPRIATE BOXES

MEMORY

- ☐ No deficit problem ☐ Moderate or intermittent deficit (explain below) ☐ Severe memory deficit (explain below)

Explanation: _____

ORIENTATION

- ☐ No disorientation ☐ Moderate disorientation/confusion (explain below) ☐ Severe disorientation (explain below)

Explanation: _____

JUDGMENT

- ☐ Unimpaired ☐ Mildly Impaired (explain below) ☐ Severely Impaired (explain below)

Explanation: _____

- Are you aware of any injury or accident that the patient has suffered due to deficits in memory, orientation or judgment? ☐ Yes ☐ No
If Yes, please specify: _____
- Does this patient retain the mobility or physical capacity to place him/herself in a situation which would result in injury, hazard or accident? ☐ Yes ☐ No
- Do you have any additional information or comments? _____

CERTIFICATION

I certify that I am licensed to practice in the State of California and that the information provided above is correct.

SIGNATURE OF PHYSICIAN OR MEDICAL PROFESSIONAL:	MEDICAL SPECIALTY:	DATE:
ADDRESS:	LICENSE NO.:	TELEPHONE: ()

RETURN THIS FORM TO: